COMMONWEALTH OF KENTUCKY
PERSONNEL CABINET
DEPARTMENT FOR EMPLOYEE INSURANCE

HEALTH INSURANCE UPDATE FORM

Do NOT use this form to add or drop dependents. Insurance Coordinator must complete shaded areas

GENERAL INFORMATION (*REQUIRED*)

SOCIAL SECURITY NUMBER	COMPANY NUMBER
NAME	COMPANY NAME

☐ TERMINATION

DATE EMPLOYMENT TERMINATES_____ DATE INSURANCE TERMINATES_____

☐ REINSTATE _____

☐ TRANSFER

- ***To Be Completed By The New Company***
- ***No Changes To Current Coverage Are Allowed On This Form***

PRIOR COMPANY #_____ NEW COMPANY #_____ DATE EMPLOYMENT CHANGED _____

COVERAGE END DATE FROM PRIOR COMPANY # _____ COVERAGE BEGIN DATE AT NEW COMPANY #_____

CURRENT COVERAGE

PLAN CODE/CARRIER:_____ **LEVEL:** S PP C F Waive

OPTION: Essential Enhanced Premier **CROSS-REFERENCE?** Y

COUNTY OF COVERAGE: Home Work Contiguous **SMOKING STATUS:** Y N

NEW WORK COUNTY NAME (if applicable) _____

COMMONWEALTH CHOICE PARTICIPANT? **Y** **N**

OTHER CHANGES OR CORRECTIONS FOR SELF ☐ SPOUSE ☐ CHILD ☐

☐ **NAME** **NEW** _____

PREVIOUS _____

☐ **NEW ADDRESS** _____

NEW HOME COUNTY NAME (if applicable) _____

☐ **SSN** **CORRECT**_____ **INCORRECT** _____

☐ **DATE OF BIRTH** _____ ☐ **OTHER** _____

EMPLOYEE SIGNATURE	DATE	COORDINATOR SIGNATURE	DATE

Insurance Coordinator: Mail this form to 200 Fair Oaks Ln., Suite 501, Frankfort, KY 40601 Phone: (502) 564-1205 Fax: (502) 564-1085

WHITE – ENROLLMENT INFORMATION BRANCH YELLOW – EMPLOYER PINK – EMPLOYEE Revised 04.15.05